APPENDIX 6
PRIOR AUTHORIZATION PSYCHOTHERAPY ATTACHMENT (PA/PSYA) COMPLETION INSTRUCTIONS

The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization. Carefully complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

EDS
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding completion of the Prior Authorization Request Form (PA/RF) and/or the Prior Authorization Psychotherapy Attachment (PA/PSYA) may be addressed to EDS' Telephone/Written Correspondence Unit.

GENERAL INSTRUCTIONS:
The information contained on this prior authorization psychotherapy attachment is used to make a decision about the amount and type of psychotherapy which is approved for continued Medical Assistance reimbursement. Please complete each section as completely as possible and include any material which you believe is of help in understanding the necessity for the services you are requesting. Where noted in these instructions, you may substitute material which you may have in your records for the information requested on the form.

When submitting the first prior authorization request for a particular individual, please fill out page one and two. For continuing authorization on the same individual, it is not necessary to rewrite page one, unless new information has caused you to change any of the information on this page (e.g., a different diagnosis, belief that intellectual functioning is in fact significantly below average). When there has been no change in the page one information, please submit a photocopy of this page along with your updated page two. Medical consultants reviewing the prior authorization request have before them a file containing the previous requests; therefore, updates and progress need to reflect changes only from the information contained on the previous request.

Prior authorization for psychotherapy is not granted when another provider already has a prior authorization in place for psychotherapy services to the same recipient. In these cases, the recipient must request that the previous provider notify EDS that they have discontinued treatment with the recipient. The new provider must complete both page one and two for the initial prior authorization request.

RECIPIENT INFORMATION:

ELEMENT 1 - RECIPIENT'S LAST NAME
Enter the recipient's last name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 2 - RECIPIENT'S FIRST NAME
Enter the recipient's first name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL
Enter the recipient's middle initial exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the recipient's 10-digit Medical Assistance identification number exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 5 - RECIPIENT'S AGE
Enter the age of the recipient in numerical form (e.g., 45, 60, 21, etc.).

PROVIDER INFORMATION:

ELEMENT 6 - PERFORMING PROVIDER NAME AND CREDENTIALS
Enter the name and credentials of the therapist who will be providing treatment (e.g., I.M. Provider, M.D. or I.M. Provider Ph.D.).

ELEMENT 7 - PERFORMING PROVIDER'S MEDICAL ASSISTANCE NUMBER
Enter the eight-digit Medical Assistance provider number of the performing provider. (Not required for 51.42 Board-operated clinics.)

ELEMENT 8 - PERFORMING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including area code, of the performing provider.

ELEMENT 9 - SUPERVISING PROVIDER'S NAME
Enter the name of the physician or psychologist who is supervising the treatment if the performing provider is a master's level therapist.

ELEMENT 10 - SUPERVISING PROVIDER'S MEDICAL ASSISTANCE NUMBER
Enter the eight-digit Medical Assistance provider number of the physician or psychologist who is supervising the treatment if the performing provider is a master's level therapist. (Not required for 51.42 Board-operated clinics.)

ELEMENT 11 - PRESCRIBING PROVIDER'S NAME
Enter the name of the physician who wrote the prescription for psychotherapy.

ELEMENT 12 - PRESCRIBING PROVIDER'S MEDICAL ASSISTANCE NUMBER
Enter the eight-digit Medical Assistance provider number of the physician who wrote the prescription for psychotherapy. If the physician is not WMAP-certified, enter the physician's name.

DOCUMENTATION:

A. DIAGNOSIS: Enter the diagnosis codes and descriptions from the most recent version of DSM. Axis IV and V are optional, but are strongly encouraged when a provider is requesting a continuing authorization for a recipient.

B. DATE TREATMENT BEGAN: Date of first treatment by this provider.

C. DIAGNOSED BY: Indicate the procedure(s) used to make the diagnosis.

D. CONSULTATION: Indicate whether there was a consultation done with respect to the recipient's diagnosis and/or treatment needs. Indicate why the consultation was needed.

E. RESULTS OF CONSULTATION: Summarize the results of this consultation or attach a copy of the consultant's report.

F. PRESENTING SYMPTOMS: Enter the presenting symptoms and indicate their degree of severity. This information may also be provided as part of an intake summary which you may attach to this request form.

G&H. INTELLECTUAL FUNCTIONING: Indicate whether intellectual functioning is significantly below average (e.g., I.Q. below 80). If "yes," indicate the IQ or intellectual functioning level.

I. HISTORICAL DATA: This information may be submitted in the form of an intake summary, case history, or mental status exam as long as all information relevant to the request for treatment authorization is included.

J. PRESENT GAF: Enter the global assessment of functioning scale score from the most recent version of DSM. For continuing authorization requests, indicate whether the recipient is progressing in treatment, using measurable indicators when appropriate.

K. PRESENT MENTAL STATUS/SYMPTOMATOLOGY: Indicate the recipient's current mental status and symptoms. For continuing authorization requests, indicate the progress that has been made since the beginning of treatment or since the previous authorization. This information may be supplied in the form of an intake summary or a treatment summary as long as the summary presents a crystallization of the progress to date. It is

not acceptable to send progress notes which do not summarize the progress to date.

L. UPDATED HISTORICAL DATA: For continuing requests, indicate any new information about the recipient's history which may be relevant to a determination of the need for continued treatment.

M. TREATMENT MODALITIES: Indicate the treatment modalities to be used.

N. NUMBER OF MINUTES PER SESSION: Indicate the length of session for each modality.

O&P. FREQUENCY OF REQUESTED SESSIONS AND TOTAL NUMBER OF SESSIONS YOU ARE REQUESTING: If you are requesting sessions more than once a week, please indicate the need for this. If you anticipate a series of treatment which is not regular (e.g., frequent sessions for a few weeks, with treatment tapering off thereafter), indicate the total number of hours of treatment you are requesting, the time period over which you are requesting the treatment, and the expected pattern of treatment. The total hours must match the quantity(ies) indicated on the PA/RF.

EXAMPLE: 15 hours of treatment is requested over a 12-week period. The recipient attends a one and one-half hour group every other week (6 groups for a total of 9 hours). There are individual sessions of one hour weekly for four weeks, and every other week for the next four weeks (6 individual sessions for a total of 6 hours).

Q. PSYCHOACTIVE MEDICATION: Indicate all the medications the recipient is taking which may be affecting the symptoms you are treating. Indicate whether a medication review has been done in the past three months.

R. RATIONALE FOR FURTHER TREATMENT: Indicate the symptoms or problems in functioning that require further treatment. If recipient has not progressed in treatment thus far, indicate reasons for believing that continued treatment is of help.

S. GOALS/OBJECTIVES OF TREATMENT: A treatment plan may be attached in response to this item.

T. STEPS TO TERMINATION: Indicate how you are preparing the recipient for termination. When available, indicate a planned date of termination.

U. FAMILY MEMBERS: If an individual provider is seeing more than one family member in individual psychotherapy, this requires adequate justification.

RECIPIENT AUTHORIZATION: Signature indicates the signer has read the form. Signature is optional.

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In addition to the above information, we need the following to process your prior authorization request:

1. The performing provider(s) signature on the PA/PSYA. Read the Prior Authorization Statement before dating and signing the attachment.

2. The supervising provider's signature is required only if the performing provider is not a physician or psychologist.

3. Attach a copy of the signed and dated prescription for psychotherapy. The initial prescription must be dated within three months of receipt by EDS. Subsequent prescriptions must be dated within 12 months of receipt by EDS.

NOTE: If a physician is the performing provider, a prescription need not be attached.